PTU-202 FLEXIBLE SIGMOIDOSCOPY AS A SCREENING TOOL FOR BOWEL CANCER- TIME FOR STANDARDISATION!

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Introduction Flexible sigmoidoscopy (FS) has been shown to offer substantial reduction in the incidences of and mortality from distal colorectal cancer and is soon to become the new screening method. Although quality markers for colonoscopy have been widely adopted in the UK, similar practice for FS is variable. In order for this procedure to be used as an effective screening tool it will need standardisation in term of quality assurance.

Methods It was a retrospective study which was carried out using an endoscopy database to identify patients who had FS performed during 2009–2011 in three district general hospitals serving a population of 600,000. The patient’s age, sex, extent of examination, grade of endoscopist, use of medications, procedure tolerance, bowel visualisation and missed left sided lesions were investigated. A complete examination was defined as a procedure when the scope was passed to the splenic flexure or beyond. Mucosal visualisation and patient tolerance were graded as good, fair and poor.

Results A total of 2823 procedures were recorded, of which 87.5% were carried out as an out-patient. In 56.7% of cases the scope was passed to the splenic flexure or beyond, while examination was limited to descending colon in 20.2%, sigmoid colon in 18.7% and rectum in 4.6%. Poor bowel preparation accounted for procedure failure in 5.7%, pain for 1.5% and anatomical complexities and pathology encounter in 1%, while in 94.1%, there were no limitations. 94.2% of procedures were performed without sedation. Good mucosal visualisation was achieved in 76.1% and the procedure was well tolerated in 80.7%. 2% of the patients used entonox

Conclusions Pathologies were detected in 58.8% of the cases while procedure was complete due to; severe diverticulosis, obstructive malignancy, adhesions, excess looping, high risk of perforation and instrument inadequacy. Renal impairment (serum creatinine rise ≥1.5-fold from the reference value within 8 days) was identified in 1.5% of patients. Mucosal visualisation and patient tolerance were grade wide variability in FS practice in the UK, similar practice for FS is variable. In order for this procedure to be used as an effective screening tool it will need standardisation in terms of quality assurance.

Competing interests None declared.

REFERENCES


PTU-203 COLONOSCOPIC INDICATIONS AND OUTCOMES IN PATIENTS AGED OVER 80: ARE WE COMPLYING WITH BSG GUIDELINES?

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Introduction Colonoscopy in patients aged over 80 can be a high risk procedure due to increased comorbidty and risk of procedural complications. This audit was carried out to ensure that colonoscopies were being performed appropriately, with respect to the indication, in accordance with BSG guidance; with the aim of improving safety and appropriateness of procedure for this sensitive group of patients.

Methods We retrospectively reviewed 158 colonoscopies over a 16-month period in patients over the age of 80. Data were collected from medical records, the Endoscopy Reporting System, referral letters and the Pathology system. Audit measures included the indications for colonoscopy, comorbidity, outcome, completion rate and complications such as; renal impairment due to bowel preparation, readmissions within 8 days from the procedure and mortality within 30 days.

Results 6.35% (10/158) of colonoscopies were carried out inappropriate in relation to the indication. Inappropriate indications included nornocytic anaemia, abdominal pain, weight loss, short history (<6 weeks) of a change in bowel habit. The rate of inappropriate colonoscopy in relation to co morbidity was 5.06% (5/158). Significant co-morbidities included triple vessel disease and ongoing angina, recent myocardial infarction, symptomatic heart failure, pulmonary embolism and previous stroke. The rate of inappropriate colonoscopy with respect to outcome was 5.7% (9/158) due to a combination of inappropriate indication and high risk procedure with normal findings. 18% (29/158) of colonoscopies were incomplete due to; severe diverticulosis, obstructive malignancy, adhesions, excess looping, high risk of perforation and instrument inadequacy. Renal impairment (serum creatinine rise ≥1.5-fold from the reference value within 8 days) was identified in 1.5% of patients.

Conclusion Colonoscopy can be a high risk procedure in patients over the age of 80. Patients should be selected carefully to ensure that the benefits from the procedure outweigh the risks. The need for colonoscopy should be questioned in elderly patients in whom colonoscopy findings will not significantly affect management and for such patients alternative methods of imaging may be more appropriate.

Competing interests None declared.

REFERENCES

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Introduction Large adenomatous colonic polyps (>10 mm) are associated with an increased risk of development of adenocarcinoma. Recent national guidelines require the ability to distinguish polyps above and below 10 mm in size to determine the optimal surveillance interval. There is no standardised technique to measure polyp size either in the literature that underpins current guidelines or in practice. Visual estimation at endoscopy is widely used. Small prospective studies have shown this method to be inaccurate when compared to direct measurement in the pathology department.

This retrospective study aims to establish the accuracy of visual estimation of adenoma size: a comparison with direct measurement in the pathology department.

Methods A search for the word “polyp” was performed on the pathology reports for all colonoscopies and flexible sigmoidoscopies performed during a 1-year period. The pathology and endoscopy reports of the resultant cases were reviewed. Only adenomas completely removed by snare polypectomy without lifting and
RESEARCH ARTICLE

Gastric cancer has a vastly superior survival rate and may be amenable to endoscopic resection. Diagnostic gastroscopy provides a unique opportunity to diagnose early gastric neoplasia, whatever the indication; however intraluminal mucus and saliva can obscure mucosal visualisation and potential detection of these lesions. The aim of this study was to investigate whether the use of a premedication solution containing the mucolytic agent N-acetylcysteine and the surfactant simethicone improves mucosal visualisation within an unselected UK diagnostic gastroscopy service.

Methods 75 consecutive patients were recruited from a single endoscopist’s diagnostic gastroscopy list. These were randomised into three groups: 1. Standard control—clear fluids only for 6 h, NBM for 2 h; 2. Placebo control — standard control + 100 ml sterile water (given 20–30 min prior to gastroscopy). 3: Solution — standard control + 100 ml investigated solution (20–30 min prior).

The endoscopist was blinded to patient preparation. Inadequate mucosal visualisation was measured by assessing fluid/mucus during gastroscopy that could not be suctioned and required flushing with water. The volume of flush, the site at which it was used and the procedure time were recorded.

Results All three groups showed no statistical difference for age, gender, priority or indication. The mean volume of flush required to obtain clear mucosa was significantly less in the solution group (12.1 ml (5.5–20.7)) compared to the standard control group (54.2 ml (39.2–69.2), p<0.00003) and the placebo control group (61.0 ml (44.6–77.4), p<0.00001). This significant difference was identified across all sites recorded in the upper GI tract, bar the OGJ where very little stubborn mucus was identified in all three groups. 61% of the solution group required no flushing at all, significantly more than the standard control group (15%, p<0.0002) and the placebo control group (9%, p<0.0005). Mean procedure time was less in the solution group (8.5 min (7.1–9.9)) compared with the standard control (10.4 min (8.5–12.3), p<0.075) and placebo control (10.5 min (9.3–11.7), p<0.028). When patients on Barrett’s surveillance are excluded this is more significant. Solution (7.2 min (6.2–8.2)) vs. standard control (8.8 min (7.3–10.1), p<0.041) vs placebo control (10.2 min (6.8–11.8), p<0.0031).

Conclusion Premedication with NAC and simethicone is a low cost and well-tolerated method of dramatically improving visibility and procedure time during diagnostic gastroscopy. This simple intervention may improve detection of early gastric cancer.

Competing interests None declared.

REFERENCES


PTU-206 STENT EXPULSION IN DIAGNOSTIC ERC

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Introduction Patients who have a high risk of developing pancreatic cancer (FPC) may have pre-malignant molecular changes and have been enrolled in a EUROPAC study to conduct diagnostic ERCP for the collection of pancreatic juice.1,2 These otherwise healthy patients have been identified as a higher risk group for ERCP-induced pancreatitis.3 To reduce the incidence of post-ERCP pancreatitis a self-expelling plastic stent is routinely inserted into the pancreatic duct after ERCP. Stents have been shown to reduce pancreatitis in small cohorts but previous spontaneous intraluminal migration has been quoted at 67% for pancreatic stents.4,5

Methods Prospective observational study of 24 patients who underwent ERCP and secretin stimulated collection of pancreatic juice as part of the EUROPAC study. No pancreatic or biliary disease was present. In all patients a plastic stent was inserted (3 cm 5 Fr Zimmon, Cook Medical®) to avoid post-ERCP pancreatitis. Plain

PTU-205 PRE-MEDICATION WITH N-ACETYLCYLSTEINE AND SIMETHIONE IMPROVES MUCOSAL VISUALISATION DURING GASTROSCOPY. A RANDOMISED, CONTROLLED, ENDOSCOPIST-BLINDED STUDY

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Introduction The detection of early cancer during gastroscopy in the western world is poor. UK studies have demonstrated up to a 15% miss rate during diagnostic gastroscopy for early neoplasia. Early

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PTU-205 PRE-MEDICATION WITH N-ACETYLCYLSTEINE AND SIMETHIONE IMPROVES MUCOSAL VISUALISATION DURING GASTROSCOPY. A RANDOMISED, CONTROLLED, ENDOSCOPIST-BLINDED STUDY

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Introduction The detection of early cancer during gastroscopy in the western world is poor. UK studies have demonstrated up to a 15% miss rate during diagnostic gastroscopy for early neoplasia. Early